HIGH CHOLESTEROL ACTION PLAN

Name: _____

Medical Provider's Name:	Case Manager's Name:	Medical Social Worker's Name:
Phone:	Phone:	Phone:

THINGS TO DO EVERYDAY:

- ☐ Take my medicines as directed
- ☐ Keep a healthy weight
- ☐ Exercise regularly, such as walking for 30 minutes a day
- ☐ Eat a diet that includes 5 or more servings of vegetables and fruits daily
- ☐ Eat a diet high in fiber, low in saturated fat and cholesterol
- ☐ Bake, broil, grill, roast, steam and poach food
- ☐ Eat lean cuts of meat, such as skinless chicken and turkey or fish
- ☐ Use liquid vegetable oils high in unsaturated fat-for example; olive oils
- ☐ Read labels for fat content

THINGS TO AVOID:

- ☐ Saturated fats – especially in baked goods
- ☐ Fried foods
- ☐ Whole fat foods including ice cream, cheese and milk
- ☐ Processed meats including bacon, sausage and bologna
- ☐ Egg yolks or whole eggs
- ☐ Butter, shortening, stick margarine, coconut oil and products high in fat
- ☐ Drinks and foods with added sugars
- ☐ Tobacco products

NOTES:

_____

_____

_____

I WILL CALL MY MEDICAL PROVIDER TODAY IF:

- ☐ I am having problems with my medicines
- ☐ I have tired or aching muscles

I WILL DISCUSS WITH MY MEDICAL PROVIDER:

- ☐ Changes in diet
- ☐ Activity/Exercise
- ☐ Cholesterol lowering medicines
- ☐ Yearly flu vaccine

I WILL CALL 911 IF:

- ☐ I have chest, throat or arm tightness or pressure with or without shortness of breath, a cold sweat or nausea
- ☐ I have a sudden, severe headache with no known cause
- ☐ I have sudden weakness or numbness of my face, arm or leg
- ☐ I have sudden confusion, trouble speaking or understanding others
- ☐ I have sudden loss of balance, dizziness or difficulty seeing

GOALS:

Date:	My Weight:	My Goal:
Date:	My Blood Pressure:	My Goal:
Date:	My LDL Cholesterol:	My Goal:
Date:	My Triglycerides:	My Goal:
Date:	My HDL Cholesterol:	My Goal:
Date:	My Total Cholesterol:	My Goal:
Date my last Lipid Profile was done:		
Date that my next Lipid Profile is due:		

HIGH CHOLESTEROL ACTION PLAN

MY ACTION PLAN

Goal: Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)	Action: A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important 1 2 3 4 5 6 7 8 9 10 Totally important

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or e-mail and date/time):